



Thank you for your interest in Battle Buddies. Battle Buddies provides veterans disabled while serving our country with quality trained service dogs for PTSD.

In order to qualify to our program you must meet the following basic criteria (other acceptance criteria may be required on a case-by-case basis): You must have military service after September 11, 2001. You must have a verifiable diagnosis of PTSD or TBI. Your character of service must have been (or still be) honorable, verified with DD214 member-4. You must have a stable living environment. You must be free of substance abuse. You must not have a felony conviction or any crimes against animals. You must not have more than two dogs in your home. Our Applicant Review Committee will screen your completed applicant packet and determine if you meet the necessary requirements.

To apply for a service dog from Battle Buddies, the following are required:

Completed Skills Questionnaire for Service Dog Placement _____

Consent to Contact _____

Two letters of personal reference including names and addresses

The contents of the letter should include why you would be a good candidate. These personal references should not be from immediate family members, but rather a minister, teacher, co-worker, Letter from doctor or psychiatrist explaining your diagnosis and why you would be a good fit. _____

Member-4 copy of DD214 (If applicable) _____

If still active duty, a letter from your chain of command is required.

Please sign and date to acknowledge you have completed the application in full.

Applicant Signature _____

Battle Buddies Inc.

APPLICANT INFORMATION

Full Name: _____

Current Address:

Street Address Apartment/Unit # _____

City County State ZIP Code _____

First Previous Address (Required):

Street Address Apartment/Unit # _____

City County State _____

ZIP Code _____

Second Previous Address (Required):

Street Address Apartment/Unit # _____

City County State ZIP Code _____

Home Phone: _____ Cell Phone: _____

Personal E-mail Address: _____

Social Security Number: _____

Birth Date (MM/DD/YY): _____

Age ___ Height ___ Weight ___

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Significant Other's Name: _____

Significant Other's Email: _____

Significant Other's Phone: _____

Name of nearest relative or emergency Contact _____

Military Service: Branch _____

Dates of Service (MM/DD/YY): _____ to _____ Location _____

Dates of Service (MM/DD/YY): _____ to _____ Location _____

Rank: _____ MOS _____

Type of Discharge: _____

Have you been reviewed by a medical board with the last 12 months?

Fit: _____ Unfit: _____ Not reviewed: _____

Highest level of education: _____

Educational degrees: _____

MEDICAL INFORMATION

Please be as specific as possible, as this sections aids us in assigning and training a service dog that will be most suited for your current and future conditions.

What are your disabilities? _____

Physical impairments and/or degenerative conditions?

Primary Diagnosis: _____

Date of Onset or Diagnosis (MM/DD/YY): _____

Secondary Diagnosis: _____

Date of Onset or Diagnosis (MM/DD/YY): _____

Verbal Skills – On a scale of 1 (non-verbal) to 5 (fluent with clear annunciation), please rate the quality of your verbal communications. Non-verbal 1 2 3 4 5 Verbal

Please describe and rate your physical strength:

Medications: _____

How does your disability affect your daily life? What are your functional limitations?

Describe problems carrying items, problems walking distances, problems leaving home on your own, ability to be in crowds, ability to be in large groups, driving a car, and or others.

Do you handle any of the following by yourself, with assistance or is it provided by others such as a caretaker?

Routine medications: _____

Finances: _____

Housecleaning: _____

Meals: _____

Getting dressed: _____

Running errands: _____

Personal care: _____

Response (1) (2) (3) (4) (5) 5 being the extreme

1 Repeated, disturbing memories, thoughts, or images of a stressful experience from the past. ____

2 Repeated, disturbing dreams of a stressful experience from the past. ____

3 Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it). ____

4 Feeling very upset when something reminded you of a stressful experience from the past. ____

5 Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past. ____

6 Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it. ____

7 Avoid activities or situations because they remind you of a stressful experience from the past. ____

8 Trouble remembering important parts of a stressful experience from the past. ____

9 Loss of interest in things that you used to enjoy. ____

10 Feeling distant or cut off from

other people.____

11 Feeling emotionally numb or being unable to have loving feelings for those close to you.____

12 Feeling as if your future will somehow be cut short.____

13 Trouble falling or staying asleep.____

14 Feeling irritable or having angry outbursts.____

15 Having difficulty concentrating.____

16 Being "super alert" or watchful on guard.____

17 Feeling jumpy or easily startled ____

CRIMINAL HISTORY

Have you been charged with any criminal offenses, INCLUDING traffic violations?

Yes No

If yes please

explain _____

Have you ever been convicted of any crimes, INCLUDING traffic violations?

Yes No

If yes please

explain _____

Do you have a history of violence?

Yes No

Do you have a history of harming animals?

Yes No

WORK/EDUCATION

Are you presently employed? Yes No / Fulltime or Part-time (# hours per week) _____

Employer: _____

How do you get to/from work? _____

Describe your work environment (large/small office, high rise, downtown, suburban, rural location, indoors, outdoors, etc.) _____

If not presently working, do you plan on becoming employed?

Do you receive support from services such as Vocational Rehabilitation, or Veterans Medical Support? _____

HOME ENVIROMENT

How many people live in your household? _____

Please give names/ages/relationship to you:

Is anyone in your home allergic to dogs? Yes No

Do you have pets? _____ How many? _____

Would you be willing to relocate a current pet if they are not suitable to get along with a service dog?

Yes No

Please list name, breed and age of pets:

Veterinarian: _____

Phone: _____

Do you own or rent your home? Own or Rent

Describe your home and neighborhood (house, apartment, mobile home, size of yard, fenced or un-fenced, city, suburb, country, etc.)

Is your home fully accessible to you? Yes No

What type of support is available to assist you with care of your service dog (veterinarian visits, feeding, bathing, etc.) in the event you are unable to perform these tasks both at home and at work or school?

We ask that you agree and are aware of the following conditions.

The canine you will be partnered with is NOT a family pet- it is to be treated as a service dog and the functions it was trained for are to be maintained.

INITIALS: _____

The canine will spend the majority of its time with the warrior it was assigned to including school, work as well as social events. The canine is not to be left unattended in a vehicle or kennel or any other space.

INITIALS: _____

The canine is not to be released off leash except in a controlled environment such as a fenced yard. Exercise and breaks must be conducted on leash unless it is done in a secure area.

INITIALS: _____

The Battle Buddies team are considered ambassadors of the Battle Buddies organization and the Service Dog Community and as such are expected to adhere to all regulations governing service dogs, maintain your dog's health, grooming and certifications and training.

INITIALS: _____

CONSENT TO CONTACT FORM

I, _____, give consent for the health care professionals listed below to release to Battle Buddies, Inc. information relating to my current health, mental health, and home/work/school environments. I understand that the information requested is confidential, will not be released to any person or agency outside Battle Buddies Inc, and will be used for the sole purpose of assessing my qualifications for a service dog and ability to provide a suitable home for a service dog. Please list the names, addresses and phone numbers of those who are applicable:

Primary Doctor & Phone Number: _____

Address/City/State/Zip: _____

Physical Therapist & Phone Number: _____

Address/City/State/Zip: _____

Speech Therapist & Phone Number: _____

Address/City/State/Zip: _____

Occupational Therapist & Phone Number: _____

Address/City/State/Zip: _____

Recreation Therapist & Phone Number: _____

Address/City/State/Zip: _____

Psychologist/Psychiatrist & Phone Number: _____

Address/City/State/Zip: _____

Veterinarian & Phone Number: _____

Address/City/State/Zip: _